DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

Center for Medicaid and State Operations
7500 Security Boulevard
Baltimore, MD 21244-1850

November 24, 1997

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Balanced Budget Act of 1997 (BBA).

The purpose of this letter is to describe the implications of section 4714 of BBA regarding the amounts that States may pay when they comply with the requirement to pay Medicare cost-sharing for Qualified Medicare Beneficiaries (QMBs) and the protections against payment liability for QMBs.

As you know, the requirement for Medicaid to pay Medicare cost-sharing for QMBs was originally enacted in the Medicare Catastrophic Coverage Act of 1988. The State Medicaid Manual (SMM) addressing that requirement reads that States have the option to pay Medicare cost-sharing in amounts based either on the full Medicare-approved amount or on the amount that the State pays for the same service on behalf of a Medicaid recipient not entitled to Medicare. Over the years, however, some Federal courts have interpreted the Medicaid law as not giving States this choice and have required States in their jurisdictions to pay full Medicare cost-sharing for QMBs.

On August 5, 1997, the President signed into law the BBA of 1997. Section 4714 of the BBA clearly provides that States have flexibility in establishing the amount of payment for Medicare cost-sharing in their Medicaid State plans. Therefore, HCFA's policy, as described in section 3490.14 of the SMM, has been validated and all States, including those previously required by the courts to pay the full Medicare cost-sharing amount, may now take advantage of its flexibility.

The amendments made by section 4714 do not automatically effectuate any changes in a State's Medicaid reimbursement for Medicare services provided to QMBs. Therefore, a State that wishes to change its reimbursement amounts for Medicare cost-sharing must follow the usual procedures by submitting an amendment to State plan preprint pages, Supplement 1 to Attachment 4.19-B.

The general effective date for section 4714 was August 5, 1997, the date of enactment of the BBA. However, Congress specified that its provisions also apply for establishing State plan payment rates for Medicare cost-sharing before such date if State plan payment rates were the subject of a lawsuit based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and the lawsuit was pending as of, or initiated after, August 5, 1997. On the other hand, States that were party to a lawsuit that is final/nonpending and were ordered by the court, prior to August 5, 1997, to pay full Medicare cost-sharing, must pursue legal action in order to secure relief from the court's injunction to enable them to use the flexibility provided by section 4714 prospectively from the date of enactment.

A more complete explanation of the implications of section 4714 is provided as Enclosure 1 to this letter. Enclosure 2 provides a list and definitions of the various categories of dual eligibles (individuals entitled to Medicare and eligible for some type of medical assistance). Section 4714 applies to only the first category (which includes two subcategories) described in Enclosure 2.

Any questions about this provision or the contents of this letter should be directed to Robert Nakielny of my staff at (410) 786-4466.

Sincerely,

/s/
Sally K. Richardson
Director
Center for Medicaid and State Operations

Enclosures (2)

cc: All HCFA Regional Administrators

All HCFA Associate Regional Administrators for Medicaid and State Operations

Lee Partridge American Public Welfare Association

Joy Wilson National Conference of State Legislatures

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Enclosure 1

IMPLICATIONS OF SECTION 4714 OF THE BALANCED BUDGET ACT

Section 4714 of the Balanced Budget Act of 1997 clarifies the flexibility that States have when they comply with the requirement to pay Medicare cost-sharing for Qualified Medicare Beneficiaries (QMBs) and the protections against payment liability for QMBs. QMBs include those individuals who are eligible for Medicaid as QMB-only, as well as those individuals eligible for Medicaid as QMB-Plus (i.e., eligible for regular Medicaid benefits and Medicare cost-sharing assistance).

Section 4714, by its terms, applies only to the above categories of individuals, who are mandated to receive Medicare cost-sharing assistance defined in section 1905(p)(3) of the Social Security Act. Section 4714 does not affect the flexibility that has been, and continues to be, afforded States under section 1902(a)(10) of the Social Security Act to make payment for Medicaid services provided to individuals who are both entitled to Medicare and eligible for Medicaid, but not as QMBs (i.e., those who "spend down" to Medicaid eligibility). Since Congress repealed section 1902(a)(15) effective July 1, 1989, there have been no requirements in the Medicaid statute governing the rate that Medicaid must pay if the payment rate for the Medicaid services covered under the State plan is less than the amount payable by Medicare as a liable third party for a service covered by Medicare and Medicaid. To the extent that courts have derived an obligation on States to pay the full Medicare cost-sharing for dual eligible individuals who are not QMBs, they have based this finding on the QMB provisions.

Specifically, section 4714 of BBA amends section 1902(n) of the Social Security Act to clarify that a State is not required to provide any payment for any expenses incurred relating to Medicare deductibles, coinsurance, or copayments for QMBs to the extent that payment under Medicare for the service would exceed the amount that would be paid under the Medicaid State plan if the service were provided to an eligible recipient who is not a Medicare beneficiary. Thus, a State's payment for Medicare cost-sharing for a QMB may be reduced or even eliminated because the State is using the State plan payment rate. In situations where the rate payable under the State plan exceeds the amount Medicare pays, but is less than the full Medicare-approved amount, the policy described in the SMM generally continues to be viable. Section 3490.14 of the SMM requires States to pay, at a minimum, the difference between the amount Medicare pays and the rate Medicaid pays for a Medicaid recipient not entitled to Medicare.

As a reminder, the Medicaid payment rates established in the State plan should not compromise beneficiary access to care and services as required by section 1902(a)(30) of the Act. This requirement applies to Medicaid rates generally, not just in the limited context of QMBs or other dual eligible individuals.

Section 4714 also expands the Medicaid concept of "payment in full" to the Medicare program and eliminates balance billing and "bad debts" under Medicare for any Medicare beneficiary who is a QMB. It does so in two ways. First, under section 1902(n)(3), where a State's payment for Medicare cost-sharing for a QMB is reduced or eliminated because the State is using the State plan payment rate:

A. the amount of payment made by Medicare plus the amount of payment by Medicaid (if any) shall be considered to be payment in full for the service for purposes of applying any limitation under Medicare on the amount the QMB may be billed or charged for the service;

B. the QMB has no legal liability for payment to a provider or health maintenance organization defined in section 1903(m)(1) for the service; and

C. if a provider or HMO imposes an excess charge on a QMB, that entity is subject to any lawful sanction that may be imposed under Medicaid or Medicare. However, a provider or HMO may pursue payment for Medicare cost-sharing from a Medicare supplemental policy or an employer retiree health plan on behalf of the QMB.

The second way the Medicare program is affected by section 4714, is in changes to sections 1866(a)(1)(A) and 1848(g)(3)(A) of the Social Security Act. These sections, as amended, preclude Medicare providers from imposing any charge that is prohibited under section 1902(n)(3). These limitations apply both to Medicare providers with provider agreements and to nonparticipating Medicare physicians.

Enclosure 2

LIST AND DEFINITION OF DUAL ELIGIBLES

Dual Eligibles - Individuals entitled to Medicare (at least hospital insurance under Part A) and eligible for some category of Medicaid benefits. The following information describes the various categories of individuals who, collectively, are known as dual eligibles.

1. **Qualified Medicare Beneficiaries (QMBs)** - Individuals entitled to Part A of Medicare, with income not exceeding 100% of the Federal poverty level, and resources not exceeding twice the SSI limit. QMBs may be eligible for full Medicaid or may have Medicaid eligibility limited to payment of Medicare Part A and Part B (supplementary medical insurance) premiums and Medicare cost-sharing (deductibles and coinsurance) for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

    A. **QMBs without other Medicaid (QMB Only)** - Individuals entitled to Part A of Medicare, with income not exceeding 100% of the Federal poverty level, and resources not exceeding twice the SSI limit. Eligibility for Medicaid is limited to payment of Medicare Part A and Part B premiums and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. FFP equals FMAP.

    B. **QMBs with Medicaid (QMB Plus)** - Same as A. above and eligible for full Medicaid benefits for Medicaid services provided by Medicaid providers. FFP equals FMAP.

2. **Non-QMBs** - Individuals entitled to Medicare and eligible for full Medicaid benefits, but not as a QMB (typically, medically needy individuals who have to spend down income to qualify). Medicaid benefits are for Medicaid services provided by Medicaid providers, but only to the extent that the Medicaid rate exceeds any Medicare payment for the service covered by both Medicare and Medicaid. Payment of Medicare Part B premiums is optional. FFP equals FMAP.

3. **Specified Low-Income Medicare Beneficiaries (SLMBs)** - Individuals entitled to Part A of Medicare, with income above 100%, but not exceeding 120% of the Federal poverty level, and resources not exceeding twice the SSI limit. Eligibility for Medicaid benefits is limited to payment of Medicare Part B premiums. FFP equals FMAP.

4. **Qualified Disabled and Working Individuals (QDWIs)** - Individuals entitled to purchase Part A of Medicare (Medicare benefits lost because of return to work), with income below 200% of the Federal poverty level, and resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to payment of Medicare Part A premiums. FFP equals FMAP.

5. **Qualifying Individuals 1 (QI1s)** - Effective 1/1/98 12/31/02. Individuals entitled to Part A of Medicare, with income above 120%, but less than 135% of the Federal poverty level, resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. FFP equals FMAP at 100%, but is annually capped. Entitlement of individuals is limited by the availability of the capped allocation.

6. **Qualifying Individuals 2 (QI2s)** - Effective 1/1/98 12/31/02. Individuals entitled to Part A of Medicare, with income at least 135%, but not exceeding 175% of the Federal poverty level, resources not exceeding twice the SSI limit, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to partial payment of Medicare Part B premiums. FFP equals FMAP at 100%, but is annually capped. Entitlement of individuals is limited by the availability of the capped allocation.